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ACUTE RESPIRATORY DISEASES*

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WITH the knowledge that influenza and the common cold are caused by viruses, organisms quite different from the ordinary pathogenic bacteria which we have long known to be associated with acute and chronic disease of the respiratory tract, it is of great interest to clinicians to study and compare these two great classes of disease, especially from the point of view of therapeutics. We are also particularly concerned with the interdependence of virus and bacterial infection.

In the great pandemics, as in 1918, when it appears that the virus of influenza reaches a very high degree of virulence, instances are by no means rare in which such infections are overwhelming and death occurs probably as the result of the original infection alone. In the lesser epidemics, however, almost all the deaths from influenza probably result from secondary bacterial infection. Even in many fulminating cases like those so often seen in 1918, bacterial invasion may be the deciding factor as, for example, those cases of staphylococcus aureus infection reported by Dr. Gormly and me in the epidemic of 1929.

In these epidemics the usual sequence when pulmonary involvement occurs is a frank bacterial infection following the initial attack of influenza. Studies of the 1926 and 1929 epidemics here in Providence showed a great increase in the incidence of lobar pneumonia during these epidemics, and to this rule the present outbreak has been no exception.

In my own experience certain years stand out as marked in my memory. These are—after 1918—the following, 1920, 1926 and 1929. Doubtless to many of you other years will seem equally important as small epidemics have occurred almost every year between 1930 and 1940.

*Presented at joint meeting of the Rhode Island Medical Society and the Providence Medical Association, at Providence, February 7, 1944.

Recent Epidemics

We are, however, principally concerned with the very recent past. To take the winter season of 1942-43 first, my conception of what occurred is about as follows: This is based, especially, on an easily observed group of young people, students at Brown University and Pembroke College, with whom during that season I was intimately concerned. During the summer and fall of 1942 up to the Christmas holidays, the prevailing infection was a mild tracheo-bronchitis with a fairly large number of cases of demonstrable pneumonitis corresponding to that condition known to the army as "a typical broncho-pneumonia, etiology unknown" which we are accustomed in this community to call "virus pneumonia." These patients showed the usual X-ray picture and the low or normal leucocyte count. Following the opening of college in January, however, the situation changed abruptly. From this time on rather severe cases of pharyngitis occurred, characterized by a rather high fever and an intensely sore throat. These patients also showed a low leucocyte count and were recorded as cases of influenza but none of them developed pneumonitis. The throat was intensely red with hyperplastic lymphoid tissue standing out in bold relief, but no ulceration or exudate. It was interesting to me that in talking with Dr. Francis Blake of New Haven I learned that he had noted a similar change in the type of disease and felt that a different virus must be the cause of the January outbreak.

In the beginning of December 1943 another outbreak occurred in this community, apparently a part of a country wide if not world wide epidemic. This has not, I believe, subsided as yet and most of us who are doing medical and general practice are still seeing a good many cases. As usual, a great increase in the number of cases of lobar pneumonia followed. The accompanying tables show this sequence very definitely.

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Table I

	INFLUENZA				PNEUMONIA			
	P*	B*	R*	T*	P	B	R	T
Dec. 1-7	5	40	4	49	0	1	9	10
Dec. 8-14	10	34	10	54	2	2	18	22
Dec. 15-21	14	32	12	58	6	1	19	26
Dec. 22-28	8	2	11	21	6	1	22	29
Dec. 29-Jan. 4	10	12	7	29	5	3	15	23
Jan. 5-11	2	3	1	6	2	0	15	17
Jan. 12-18	3	11	3	17	0	0	12	12

*P Private patients
 B Brown University
 R Rhode Island Hospital
 T Total

Each of us can write his own description of the typical case of influenza of the present outbreak and I do not think that there would be much discrepancy. Of those that I have seen about half occurred following a few days of what was thought to be a common "cold" and in about half the onset was abrupt, with or without an actual chill. Headache, general aches and malaise were present to a varying degree but, in contrast to the students observed a year ago, sore throat was usually absent and cough was severe and persistent. In addition there were a small number of patients whose illness began with nausea and vomiting as well as fever, and in whom cough was absent. This group seemed so distinct from the others as to make one wonder if it were not the result of a different virus. In one patient, a doctor, an attack of this latter type with a rise in temperature to 103° occurred during convalescence from an attack characterized by cough, fever and a few pulmonary rales, and it seemed as if he had been sufficiently unlucky to encounter both types of infection. All these ideas as to different viruses are, of course, purely conjecture but it is to be hoped that in places where the difficult task of isolating and identifying the virus of influenza is carried on such studies will yield interesting and valuable data concerning the types of infection that have been prevalent this winter.

As regards pneumonia in the current outbreak, one can say that frank lobar pneumonia has been frequent but broncho-pneumonia more frequent. I am indebted to Dr. Lawrence Ross, recently medical resident at the Rhode Island Hospital, for the figures shown in Table II. Many of the patients with broncho-pneumonia were not given the sulfonamides. On the whole those who received the drug did slightly better than those who did not. Among patients with lobar as well as broncho-pneumonia there was a surprisingly large number who failed to react well to sulfonamide therapy—

11 out of 30 in lobar pneumonia and 11 out of 40 in broncho-pneumonia.

Principles of Treatment

As regards treatment of acute respiratory disease I believe that two main principles may be stated and that they can be applied in all but the very exceptional case. These are:

1. Virus infections are not benefited by sulfonamides.
2. Bacterial infections are usually benefited by sulfonamides. This is particularly true of most pneumococcal infections, and of many others.

I believe these two statements are generally admitted and are supported by an overwhelming amount of both experimental and clinical evidence.

In treatment therefore, if the infection appears to conform clinically to the typical picture of influenza or "virus pneumonitis", I believe that sulfonamides should be withheld on the ground that they are useless and capable of producing harmful results. In lobar pneumonia or other infections apparently due to bacteria I believe that they should usually be used, and used vigorously and with in-

Table II

1926	March—41
1929	January—68
1943	December—73
	Lobar 21
	Broncho 52
	73

Comparison of the incidence of pneumonia at the R. I. Hospital in the epidemics of 1926, 1929 and 1943-44.

Blood cultures—Pneumococcus Types 1, 2, 3, 4, 6, 7, 8
 Staphylococcus Aureus

Mortality for December and January—119 cases

- | | | | |
|-----------------------|----------|---------------------|----------------------|
| 1. Lobar pneumonia | 38 cases | 6 deaths | 19 per cent |
| One patient moribund | | corrected mortality | 16 per cent |
| 2. Broncho-pneumonia | 81 cases | 14 deaths | 23 per cent |
| Six patients moribund | | corrected mortality | 8 deaths 13 per cent |

sistence on a high fluid intake and adequate alkalization for the patient's protection. In the severer cases the use of the sodium salts of sulfadiazine or sulfamerazine with the resulting immediate high concentration of the drug in the blood, is, I believe, at times a life saving measure.

When it comes to the doubtful cases, of which there are many, I know of no reliable rule which can be applied. Every patient must be treated on the merits of his immediate condition with a number of facts taken into consideration. The leucocyte count is not by any means always a reliable guide

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SULFONAMIDES IN THE TREATMENT OF THE COMMON DISEASES OF THE UPPER RESPIRATORY TRACT*

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THE sulfonamides have been in general use for approximately seven years. Their efficacy in the treatment of certain infectious diseases has been established. The modern physician possesses a most valuable therapeutic agent, and yet with it all, there are limitations in its use. The ideal drug is not yet found that can be used effectively against all infectious diseases and at the same time be free of all harmful effects. Until that is found, it is incumbent upon the physician to be thoroughly familiar with the advantages and disadvantages of the present group of sulfonamides in order that he may use them wisely and effectively. I should like to discuss first, their indications and limitations, and second, their application to diseases of the upper respiratory tract.

Briefly, the sulfonamides are indicated in certain bacterial diseases or infections, particularly in those caused by the beta-hemolytic streptococcus, pneumococcus, meningococcus, and gonococcus. Clinical experience everywhere has shown, beyond a shadow of doubt, the efficacy of these drugs in diseases caused by these organisms. Less certain and less universally supported, are the effects of the drugs on staphylococcus, bacillus coli, influenzal bacillus, Friedlander's bacillus, bacillary dysentery, and undulant fever. It must be remembered that each individual drug is more successful in certain diseases than in others. For instance, sulfanilamide is very effective in beta-hemolytic streptococcal and meningococcal infections, more so than in those caused by the pneumococcus. Likewise, sulfathiazole is more efficient in pneumococcal pneumonia and gonococcal infections than in beta-hemolytic streptococcal or meningococcal infections.

Sulfadiazine, on the other hand, has been shown to be equally successful in beta-hemolytic streptococcal, pneumococcal, meningococcal, gonococcal, and possibly influenzal bacillus diseases. Great

things have been promised of sulfamerazine but it has not been in use long enough to be fully evaluated.

The sulfonamides, in general, have been found to be ineffective against virus diseases except for perhaps lymphocytic choriomeningitis, lymphogranuloma venereum, and trachoma.

Reactions and Complications

The ideal drug must not only be effective in all or in most infectious diseases, but also must be free of harmful effects. Individually and as a group, the sulfonamides produce a number of reactions and complications, some of which are minor and inconsequential, others severe and serious, but all are more or less preventable if care is taken in handling the drugs. Time does not permit me to discuss fully all the details of the various reactions so I shall confine myself, first, to what might be considered a sensitivity reaction and, second, to what might properly be called complications of the drugs.

As a group, the sulfonamides show, in the order of frequency, the following reactions; skin rashes with or without fever, and fever alone. These reactions make the patient hypersensitive to the particular drug used and, as a rule, also to the entire group. Subsequent use of the drugs is risky and inadvisable. It is this type of reaction which causes one to carefully consider the indications before deciding to give the drugs.

Damage to the kidneys and ureters may be properly considered a complication. This is caused by the crystals which may block the kidney tubules, pelvis, or the ureters. It is preventable if certain precautions are taken, such as a liberal fluid intake or the addition of alkali to produce alkaline urine, thus enhancing the solubility of the crystals. It may be added that it is a wise procedure to inquire into the urinary history of the patient before giving the drugs. Disturbance of the blood-forming apparatus must be carefully watched, and the drug discontinued at the first sign of injury. Damage to the liver may also be a serious complication.

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Frequency of Reactions

The question may be properly asked, when and how frequent are these reactions? Various reports and our own experience at the Charles V. Chapin Hospital have shown that rashes and fevers occur usually between the ninth and the fourteenth day of therapy. Occasionally they may develop very early or late in the treatment. That they occur frequently enough is shown by a series of 200 cases of scarlet fever treated with sulfanilamide, in which 15 per cent developed skin eruptions, with or without fever, and 7 per cent developed fever alone. In 322 cases of meningococcal infection treated with sulfadiazine at the Chapin Hospital, 5.1 per cent developed rashes and 1.5 per cent developed fever without rashes, 78.8 per cent with hematuria and 2.7 per cent gross hematuria. During the past three weeks, to mention only recent experiences, four patients were admitted to the hospital with oliguria, fever, nitrogenous retention, and crystaluria. Two of the patients had skin eruptions. They all recovered, but not without some anxiety in two of them. Peculiarly, and perhaps fortunately for us at the hospital, we have had no death which was due to agranulocytosis, but several have died from kidney damage.

Thus, the indications for the use of the sulfonamides are based primarily on the kind of bacteria involved, and the fact that the drugs are ineffective in virus diseases. The reactions and complications are handicaps which, on the whole, can be avoided by judicious use of the drugs. The most important reaction, and the one which should be avoided if possible, is sensitivity to the drugs.

Aids Against Secondary Bacterial Infection

The causes of the common diseases of the upper respiratory tract are the virus and bacteria. The common cold, the biggest nuisance of all, is caused by a virus. The sulfonamides have no influence over this disease. They likewise have no effect on the virus of influenza. However, as these diseases often pave the way for secondary bacterial infection, the drugs may be indicated and can be expected to be of inestimable value. The organisms which are common secondary invaders are, for the most part, those in which the sulfonamides are most effective, namely, beta-hemolytic streptococcus, pneumococcus, meningococcus, influenza bacillus, and staphylococcus. In actual practice, when the physician sees the patient at home, he is not able to determine precisely the incriminating organism, but he can get a pretty good idea by analyzing carefully the presenting symptoms and signs.

I do not mean to imply that this is absolutely necessary, but I think it is good medicine and certainly it is good for the soul. The important thing is the progress and extent of the lesion and the condition of the patient.

For instance, a patient with fiery red, swollen tonsils or pharynx, and enlarged cervical glands, and with a temperature course ranging between 102 and 104 degrees, has good reasons to receive the drugs. On the other hand, a patient with a similar infection of less extent, even if the temperature is 104 degrees, may recover just as promptly by the use of simple measures as with sulfonamide therapy. One must remember that patients with simple infections of the upper respiratory tract got well before the advent of the drugs and they still do recover without chemotherapy. Cases of influenza which have passed the initial stage of the disease and in which signs of secondary infection are manifested by cough, purulent expectoration, and fever, may be given the drugs without waiting for definite signs of pneumonia. Infections of the middle ear and accessory sinuses should be handled in a similar manner. If the conditions are severe and extensive, the drug may be given liberally.

Children with simple acute laryngitis do not require chemotherapy, even if the process has involved the trachea and bronchi. Contrary to some reports, I believe the infection is caused by the same virus which causes stuffy nose, rhinitis, slight fever and malaise, otherwise known as common cold. However, here again, if the physician believes that secondary infection has taken place and there are indications that it may progress, the drugs may be used profitably.

Chemotherapy as Prophylactic Measure

The most interesting and controversial question is the employment of chemotherapy as a prophylactic measure. This, indeed, would not be a problem were it not for the reactions and complications which may not only endanger the life of the patient but also may deprive him of the use of the drugs when he is in dire need of them at some future time. Even these objections would be little ground for withholding the sulfonamides if there was evidence that the procedure would eliminate the offending organisms. In a series of 400 cases of scarlet fever, we found at the Chapin Hospital that the number of beta-hemolytic streptococcal carriers at the end of four weeks of sulfanilamide therapy was the same in the 200 controlled as in the 200 treated cases. Comparable results were found with sulfadi-

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THE SULFONAMIDE TREATMENT OF RESPIRATORY DISEASES IN CHILDHOOD*

HENRY E. UTTER, M.D.

The Author, *Henry E. Utter, M.D., Member of Visiting Staff, Department of Pediatrics, Rhode Island Hospital, Providence.*

TREATMENT of respiratory disease in children has changed materially since the advent of the sulfonamides. Other drugs still have their place in the management of symptoms and must not be relegated to the background on the assumption that the sulfonamides by themselves constitute the whole treatment of any given respiratory disease. The sulfonamides do control the major number of the bacterial infecting agents, but the inflammation due to the pathological processes caused by bacteria still require the use of other remedies.

In the presence of increased bronchial secretion atropine forms a valuable adjunct to the treatment of respiratory disease. In croup, tracheobronchitis and other pathological states characterized by the presence of a thick tenacious secretion, ipecac, squills and the iodides still have their place in the treatment of respiratory disease. In pneumonia, bronchial or lobar, the Burgess method of oxygen administration relieves respiratory distress, promotes sleep and eliminates much of the exhaustion so often seen in pneumonitis.

Indications for Use of Sulfonamides

What are the indications for the use of the sulfonamides in diseases of the respiratory tract? Such a statement might seem radical and possibly be provocative of much discussion and adverse criticism, but I believe that the sulfonamides are indicated in all respiratory disease of childhood. One might except the rhinitis so often encountered in the infant in the first few weeks of life; such infants for the most part do not present toxæmia with fever but rather a local process involving the nasal mucous membrane and local treatment usually suffices. This absence of general symptoms may mean that the infant has not been hitherto sensitized to bacteria. When I make such a general statement, I would like to qualify the same by adding that in

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such general usage of the sulfonamides, that in the individual case the chemicals should be administered in proportion to the degree of illness and toxæmia rather than in terms of blood concentration of the drugs. In serious illness the proper blood concentration is important. The early work with the sulfonamides demonstrated the dosage necessary and now repeated blood concentration tests are unnecessary.

By this procedure of using the sulfonamides particularly at the onset of any acute respiratory disease much time is saved, the physician is relieved of many unnecessary visits and complications are reduced to a minimum. There have been those who contend that before administering the sulfonamides we should first give the blood a chance to develop antibodies against the infecting agent, but what evidence have we that the streptococcus, pneumococcus or staphylococcus ever produce any lasting immunity, so why wait?

Use in Virus Diseases

Should the sulfonamides be used in virus diseases? *The common cold.* In the presence of general symptoms—yes. The virus of the common cold is usually accompanied by the streptococcus or pneumococcus, both readily activated by the virus. The cold itself will do little damage, but the complicating organism will. The same holds true in virus pneumonia. Dr. Russell Cecil and co-workers in a recent contribution on the use of sulfadiazine in the common cold demonstrated that at the end of four days of administration of this drug that the bacteria in the naso-pharynx had almost entirely disappeared. However, his final conclusion was "as a result of this study we are opposed to the routine use of sulfonamides in the treatment of the common cold, but would favor their use in a few selected cases as a protection against severe secondary infection".¹ Who of us is keen enough to decide in a group of children who have head colds which ones are headed for severe secondary infections? How shall we choose? Rich or poor? Strong or weak? Certainly if the poor and careless were chosen, there would be a larger

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number of empty beds in our children's hospitals, these same beds now filled with infants and children with pneumonia not treated with sulfonamides before their admission to the hospital.

Influenza and measles, virus diseases. Metaphorically speaking, of a hundred men entering a battle, we know that a certain number will lose their lives. We have, however, no means of knowing before the conflict which soldiers will meet such a fate; of the graduating class of any college we know that at the end of five years a certain number will have passed on, but we have no knowledge at the time of graduation which ones will die. To carry the metaphor further, during an epidemic of influenza or measles, we do not know at the onset how many or which children will have cervical adenitis, otitis, pneumonia or a kidney complication due to secondary invaders. An editorial in the *New England Medical Journal* of December 9, 1943,² offers the suggestion that cases of influenza should be treated with sulfonamides to lessen the number of complications. In the past few years we have had many cases of measles. During these years I have administered the sulfonamides to every case coming under my care and to date have had no complications. Needless to state, the course of measles has been in no way altered by these chemicals. On the other hand complications of measles have been encountered in which cases the drugs had not been given during the course of the disease.

Otitis media. Catarrhal otitis may develop in the course of any respiratory disease, but if the sulfonamides are being used, it is seldom that the inflammation continues to the point of a purulent otitis. Occasionally if the Eustachian tube and middle ear are involved at the beginning of the infection, an abscess requiring myringotomy may appear even though the sulfonamides are administered at the onset of the infection. During the recent epidemic of influenza many children did have a catarrhal otitis on the fourth or fifth day of the disease, but relatively few of these cases required operative relief, the symptoms seldom lasting more than one day. If a child is encountered with a draining ear, the sulfonamides should be administered, and it is noteworthy that of these cases when mastoiditis does develop, the surgeon, for the most part, finds few organisms in the pus at operation. Certainly since the advent of the sulfonamides in our medical armamentarium, we seldom meet lateral sinus thrombosis, meningitis or brain abscess or septicæmia as complications of the mastoid disease. This is indeed a relief to those of us who

remember the devastating and prolonged infections which required weeks of treatment in the decade of 1920 to 1930 following the epidemic of influenza in 1918.

There are those who believe that the streptococcus is the primary invader in otitis media and that the pneumococcus so often found in the purulent discharge of otitis is a secondary invader to the streptococcus. If this be true, then surely the sulfonamides are indicated in all cases of acute otitis. Dr. Wesley C. Bower³ states that after myringotomy the use of sulfonamides reduces the discharge by 50%. In a series of 793 cases of otitis media purulenta mastoid disease was reduced from 136 in 1933 to 60 in 1938, a year marked by a severe type of infection.

Whooping cough. The sulfonamides are not indicated in this disease, but inasmuch as most complications of this disease are caused by the pneumococcus or streptococcus when a fever appears in the course of pertussis, it is fair to assume that the temperature arises from a secondary respiratory disease, and the sulfonamides should be given. Usually we will find in the household which harbors the case of pertussis that the adult members or other children in the family have respiratory infections which have been transmitted to the child.

Poliomyelitis. The sulfonamides will have no effect when the diagnosis has been established. When an epidemic of poliomyelitis is in progress, it is interesting to note that there is invariably a great increase in the number of children ill with an upper respiratory tract infection characterized by fever of two or three days duration, headache and vomiting. It is also noteworthy that during such an epidemic many more children than adults are afflicted. On the contrary, during an epidemic of influenza one finds adults as well as the younger members of the household infected with the virus. Surely there can be no harm in administering the sulfonamides even though a certain small proportion of these children do have a complication in the nervous system which we then, and not until then, call poliomyelitis.

Tonsillitis. Here if we consider the crypts of the tonsil as closed cavities as we classify the infections of other closed cavities such as the accessory nasal sinuses, the middle ear or meninges, the sulfonamides are of great value but must be continued for a longer period of time. In all closed cavity disease the sulfonamides do not permeate the tissues so rapidly, in the case of the sinuses more particularly owing to their poor vascular supply.

When cervical adenitis complicates the picture, the drugs must be continued for a greater length of time, but we must not forget that the swollen glands after the acute inflammation has departed may persist to some extent. Such glands will disappear by the use of general measures. Seldom do we now encounter protracted gland infections lasting six to eight weeks as we did in the presulfonamide days.

In such local infections as those involving the adenoid, tonsil, and nasal sinuses we now have access to the use of solutions of the sodium salts of the sulfonamides which form a valuable adjunct when applied topically to the infected areas.

Dosage for Children

What dose should be used in childhood? In severe or moderately severe infections a simple rule to follow is that of one gram per year of age for the first three years and after that a grain per pound body weight. In mild infections this rule need not be adhered to. In children of 6 to 10 years two to three grams a day will usually suffice in mild infections.

There is probably no danger of drug reactions inside of the first nine days. After that if there have been no indications previously, a white blood count should be done to note the presence of leucopenia. This is a far cry from the daily blood counts advised in the earlier days of the sulfonamides. In the event of vomiting the drug should be stopped, but we must not be too prone to ascribe to the drug the symptoms of the disease. In the pre-sulfonamide days how often did we ever encounter a child with a respiratory infection without some vomiting? This is about the easiest thing which a child does. Crystals of sulfathiazole or sulfadiazine must be watched for in the urine and the appearance of blood in the urine particularly from sulfadiazine would necessitate the stopping of the drug. When this symptom disappears, the drug may again be resumed. Rashes are of little importance, and when the drug is indicated, it should be continued in spite of the rash. These rashes are not precursors in childhood of graver drug reactions yet to come.

Some observers have reported that when persons have been given repeated courses of the sulfonamides that they may develop "an acquired sensitivity" to the drug. Fink and Wilson⁴ recently reported their observations on 177 children who had received more than one course of sulfathiazole or sulfadiazine. They state "our studies indicate that the use of the sulfonamides does not appear to pre-

dispose to the development of reactions on re-administration of the drug".

That children tolerate the sulfa drugs better than do adults, there can be no doubt. Infants and young children can take relatively larger doses than older children. Similarly infants and young children tolerate preventive inoculation more readily than older children. A dose of alum precipitated diphtheria toxoid given to an infant does not produce any reaction. On the contrary an older child or those in their teens may have considerable local reaction and some malaise and chilly sensations on the following day.

Preventive Outlook of Respiratory Infection

What of the future in the prevention of respiratory infection. Evidence at present is against the use of oral vaccines so commonly employed by the public. A recent issue of the Journal of the A. M. A.⁵ under current comment states, "The scientific evidence against the value of oral cold vaccines is overwhelming; consequently individual physicians and firms who deal in pharmaceuticals and who lend themselves to wholesale unrestricted distribution of such preparations are perpetrating an unwarranted commercial assault on the public pocket-book". The use of "cold vaccines" is not universally satisfactory. Certain selected cases do seem to benefit, particularly the allergic child, who is as easily sensitized to bacteria as he is to other irritants such as dust, animal emanations, grasses or weeds. The fact remains that there is no such general acceptance of cold vaccines for the prevention of respiratory disease as there is in the case of diphtheria for example. Bacteria which produce no active immunity can hardly be controlled by passive immune procedures.

That the sulfonamides may be employed in the prevention of respiratory disease may be the next step in preventive medicine. Already sodium sulfathiazole in a 2.5% solution is being employed in the form of nasal sprays and nose drops, and the results so far seem to indicate that this may constitute a satisfactory approach to the problem. There are members of the laity who are taking with a fair degree of regularity the sulfa drugs themselves in small doses. It may be hard on these human guinea pigs if the experiment fails through their intolerance to the drugs, but the layman has often provided us with experimental data through his perhaps injudicious use of medicines. The child who inadvertently swallows without harm an exceptionally large dose of some drug

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CHEMOTHERAPY OF PNEUMONIA*

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IF WE omit the various antisera there are four main types of pure or nearly pure chemicals useful in the treatment of pneumonia:

1. A group of Pittsburgh physicians¹ in 1939 found *hydroxyethylapocupreine* equal in results to antisera in the treatment of pneumococcus pneumonia. The advent of more successful agents, and since the war the lack of quinine, from which the cupreine is derived, has meant no further reports on this form of treatment.

2. *Tyrothricin* and its derivatives *gramicidin* and *tyrocidin* are active against the pneumococcus but they are too toxic for any but local or exterior use.

3. *Penicillin* gives promise of being a very effective, non toxic chemical for treatment of pneumonia of several bacterial origins. Because of limited supplies of it, and its need for military use where other agents are inactive, it will only be used when supplies are available.

4. The *sulfonamide compounds*, particularly *sulfapyridine*, *sulfathiazole*, *sulfadiazine* and *sulfamerazine* are the chemicals commonly used for treatment of pneumonia. All of them are effective against beta hemolytic streptococcus and pneumococcus, and partially effective against staphylococcus and streptococcus viridans pneumonias. They are inactive against virus infections. They are largely responsible for the fall in mortality from pneumonia since 1938. The following discussion will be limited to the use of the sulfonamide compounds and general statements usually applicable to the group will be used, instead of consideration of each drug separately.

All of the sulfonamides, since they are toxic in the human body, as well to bacteria, are detoxified in varying degrees, by combination with acetic acid to form an acetyl derivative. The acetylated compound is inactive against bacteria, and usually much less soluble than the drug from which it is derived.

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Sulfapyridine has fallen into disrepute because of a high incidence of nausea and vomiting. Sulfathiazole is so rapidly absorbed and excreted that it gives a high incidence of renal complication, when the amount being excreted exceeds the low solubility in urine. Sulfadiazine is absorbed and excreted more slowly than sulfathiazole. It was shown to be less toxic for animals, but since somewhat higher amounts are necessary in blood for the same effect, the incidence of renal complications is about the same as for sulfathiazole. Sulfamerazine is excreted slower than sulfadiazine and is more completely absorbed, and its free and acetyl compound are several times more soluble than those for sulfathiazole and sulfadiazine. If it is as effective at the same blood concentration as the other two it should be the drug of choice.

Toxic Reactions

Of the toxic reactions to sulfonamide drugs, *Nausea and vomiting, headache and dizziness and crystalluria* (usually acetylated drug) are relatively common. *Drug rash and drug fever and mild hematuria* occur rarely and when they are present it is advisable to stop the drug and force fluids. *Hemolytic anemia, jaundice (hepatitis) leucopenia with granulocytopenia* have an incidence of less than one case in one hundred. When they occur it is imperative to stop the drug and force fluids. With careful use of the sulfonamides the incidence of *anuria with azotemia* should be less than 1 per cent, but may be higher with careless administration.

This toxic effect appears mostly in dehydrated patients or in those where fluids are neglected, in the older age groups where kidney function is poor before the pneumonia, and where cardiac conditions, malnutrition, sodium intake or blood pressure interfere with urine output.

We have found that an increase in the acetylated drug in the blood occurs before the retention of nitrogen. Where drug determinations are not available to give the tip-off it is imperative to *watch fluid intake and output*. Blockage of the kidney will not occur if urine output is kept at 2500 c.c. per day. Another precaution is to keep the urine alkaline by oral administration of *sodium bicarbonate*. Urine

at pH8 will dissolve nearly three times as much drug as urine at pH6, and it would take three times as much drug by mouth to cause blockage of the kidneys, as at a urine pH of 6. Fever and infection tend to increase acid production and acid excretion, so that without sodium bicarbonate, sodium lactate, or orange juice, the urine would probably have a pH of 5 or 6, and the possibility of renal complications would be high.

Kidney disease, even with azotemia is not a contraindication to sulfonamide therapy, but it is an indication to control dosage, urine acidity and daily volume of urine very carefully.

There is no incompatibility between sulfonamide drugs and sulfate laxatives, eggs, or most general medications. Since they act by competing with or displacing p-aminobenzoic acid in the metabolism of bacteria, one should not give p-aminobenzoic acid or vitamin B complex containing it, or use local anaesthetics related to it (e. g. procaine) since they will prevent the action of the drug.

Sodium salts of the sulfonamides may be used intravenously where oral administration is impossible. They should not be mixed with glucose solutions, blood or plasma, or given subcutaneously because of their strong alkalinity. Sodium sulfapyridine in glucose solution forms a compound which is inactive against bacteria.

Only the laboratory can answer the questions:

1. What amount of drug will be present in blood after any certain dosage?
2. What amount of drug is needed in blood to assure good results?

However, it is known² that sulfonamide resistance may develop in vitro and in vivo, so that low dosage should not be used. It is important to *give adequate dosage at first*. If after 48 hours the desired result is not evident and there are 10 mg. of free drug in 100 c.c. of blood, the drug is probably inactive. If there are less than 10 mg. per 100 c.c. the dosage should be increased to obtain this figure. Usually an initial dose of two grams followed by one gram every four hours is adequate for adults. With old people this may be *too high*, and in some cases it is *too little* to treat a bacterial pneumonia successfully.

Dosages of sulfadiazine as high as 8 grams initially, 5 grams in 2 hours and then 4 grams every 4 hours has been given to young males with meningitis.³ With proper hospital control renal complications were only 6, none fatal, in 134 cases.

¹W. W. G. MacLachlan, J. M. Johnston, M. M. Bracken and G. E. Crum—The Treatment of pneumococcal pneumonia by hydroxyethylapocupreine. *Am. Jour. Med. Sci.* 197, 31-39, 1939.

²J. S. Harris and H. I. Kohn—Resistance to sulfanil derivatives in vitro and in vivo. *Science* 92, 11, 1940.

³B. A. Marangoni and V. C. D'Agati—Treatment of 134 cases of meningococcal infection with massive doses of sulfadiazine. *Am. Jour. Med. Sci.* 207, 67-77, 1944.

⁴E. E. Osgood—What the general practitioner should know about the chemotherapy of bacterial infections. *Canad. Med. Assn. Jour.* 50, 1-8, 1944.

THE SULFONAMIDE TREATMENT OF RESPIRATORY DISEASES IN CHILDHOOD

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demonstrates to us how large a dose can be tolerated.

Rheumatic fever is providing for us an experiment to demonstrate the feasibility of giving sulfonamides to prevent respiratory diseases. Many children and young people are today taking the sulfonamides in daily doses to prevent recurrences so often precipitated by the streptococcus hemolyticus. In this disease, probably another virus disease, we know that the streptococcus infection is often the precursor of rheumatic fever but not the actual cause of the condition. Is it not more than probable that the streptococcus breaks down the natural barriers provided by lymphatic tissue in the throat, so often if not always the focus of infection in this disease, to allow the entrance into the blood stream of the virus of rheumatic fever?

Administration to Rheumatics

In regard to the problem of administering the sulfonamides to rheumatics as an example of what may be ahead of us in the prevention of other respiratory diseases, may I quote from a recent communication from Dr. Homer F. Swift of The Hospital of the Rockefeller Institute for Medical Research? "The use of sulfonamides in rheumatic fever patients, as you know, must be divided into several phases. As far as our experience goes, these drugs are only of value in preventing the hemolytic streptococcal infections which are the precursors of attacks of rheumatic fever. After the streptococcal infection has occurred, they do not prevent the onset of rheumatic attacks. In other words, they are of little value in this respect when given in phase one or two.

We have seen no beneficial effects with them when given to a patient with active rheumatic fever, and in some instances, the patient's symptoms seem to have been made worse by sulfonamides. Their use, therefore, is limited to the prevention of hemolytic streptococcal infections where they have dis-

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GENERAL RECOMMENDATIONS OF WELFARE COMMISSION

(The Journal publishes below the major recommendations made by the State Commission on Public Welfare Institutions after a two year study by authorization of the General Assembly)

The Commission. Col. Patrick H. Quinn, Chairman; Alex M. Burgess, M.D.; Rev. William R. Clark, O.P.; Clemens J. France; Harry Loeb Jacobs; Mrs. Lucille P. Leonard; Charles A. McDonald, M.D.

CHAPTER III Recommendations

I. IN GENERAL

A. Department of Public Welfare Institutions

There shall be in the State Government a Department of Public Welfare Institutions. This Department shall have jurisdiction, supervision and control of the following State Public Welfare Institutions and the persons therein:

1. The State Hospital for Mental Diseases located in the City of Cranston comprising the buildings and lands, patients and employees. (At present there are approximately 2788 patients with an appropriation in 1943 of \$833,050.)

2. The State Infirmary, to be known hereafter as the "John Clarke Hospital and Medical Center", to occupy the present buildings and also the building now known as the "State Reformatory for Men"; this latter building is to house the State Medical Center. (In the State Infirmary at the present time there are 865 patients and in the winter months the capacity is not adequate. Converting the building now known as the "State Reformatory for Men" will relieve the need of the construction of new buildings for the State Infirmary. The capacity of the Reformatory building is approximately 250 prisoners and therefore the building would be able to accommodate about 250 patients.

3. The State Sanatorium for Tuberculosis located at Wallum Lake and now within the Department of Public Health. (This Hospital contains 458 patients.)

4. The Exeter School, to be renamed the "Gleason School and Hospital", to be enlarged to accommodate 1,000 patients.

(These four medical institutions have a combined population of 4980 and are increasing in population every year.)

5. The State Prison and Providence County Jail, to be known hereafter as the "State Prison, Jail and Reformatory for Men", to occupy the buildings now known as the "State Prison and County Jail". (At the present time there are 230 men in the prison; only 156 in the jail; and but 112 in the State Reformatory for Men. Thus the total population of these three at the present time is 498 prisoners.)

6. The building now used as the State Reformatory for Men, to be abandoned as such and transferred to the John Clarke Hospital, and to be known as the "Medical Center".

7. The State Reformatory for Women, to be known hereafter as the "State Prison, Jail and Reformatory for Women" and to be housed in a new building recommended to be built on land owned by the State in back of the present Oaklawn School for Girls. The building in which the State Reformatory for Women is located to be abandoned as such and to become when remodeled an extension of the criminal insane ward of the Mental Hospital for the housing of defective delinquents who need care, treatment and restraint.

8. The Oaklawn School for Girls, to be called hereafter the "Harriet Ware School for Girls", to remain in its present location.

9. The Sockanosset School for Boys to be called the "Whittemore School for Boys", to remain in its present location. (There are 180 boys in this School.)

(N. B. The present total population of the State Prison and Providence County Jail, the Reformatory for Men, and Reformatory for Women, the Oaklawn School for Girls and the Sockanosset School for Boys is 798. Of this number 678 are males and 120 females)

10. The State Home and School, with a population of 131 and an appropriation of \$103,690, to be abandoned.

11. The Soldiers' Home at Bristol, with a population of 66 and an appropriation of \$57,795. to be abandoned.

These two institutions comprise 197 persons with a combined appropriation of \$161,485. The persons herein cared for should be distributed to other institutions in this department; the children who are sick, to the John Clarke Hospital; the children who are mentally defective, to the Gleason School and Hospital; and in the case of children with conduct disorders, to the Whittemore School for Boys, the Harriet Ware School for Girls.

These above named institutions have a total population of 5975. This population is sharply divided into two groups: (1) 798 of this total number are in the corrective institutions; (2) and 5177 persons are in institutions which provide medical supervision, care and treatment. Of the total population of this Department of Public Welfare Institutions 87% are patients and 13% are prisoners. In view of the fact that over 50% of prisoners are admittedly psychotic and therefore present primarily a medical problem, the number of state wards whose condition is not essentially of medical interest is reduced to less than 7%.

The Commission recommends the separation of the State Institutions from the Department of Social Welfare and for many reasons, not least of which is the fact that Welfare services and institutional services are unlike in kind and function. Welfare Services comprise the good-will of society to aid and care for persons in society who, through no fault of their own, need help and guidance. Institutional services, on the other hand, contain those people who are poor, sick or bad, whom society has isolated for care, treatment, or punishment and restraint, for the welfare of the general public as well as the patients and prisoners themselves. The objectives are entirely different. Social Welfare is for persons in society; public welfare is for persons outside of society. Thus, to have Public Welfare a part of Social Welfare is like giving to the Director of Public Aid in Providence, who looks after the poor, the control and supervision of the Police department and the hospitals of the City of Providence.

This Commission is unable to understand why dependent children and other persons who are poor through no fault of their own and are, therefore, receiving State aid, should be cast into the same category with prisoners of all types by being placed under the same management, the same general supervision, and the same sole Director.

B. *Director of the Department*

There shall be a Director of this Department of Public Welfare Institutions appointed by the Governor. The Commission further recommends that insofar as approximately 93% of the population of this department needs medical care, supervision and individual study, that the Director be a physician, a graduate of a recognized medical school, who has had training and experience in the administration of hospitals for not less than ten years; and that in the selection of a Director there should be a countrywide search. The Director of this Department should have a salary commensurate with his medical training and medical and public responsibilities; such salary should be of a definite sum and should not include housing and maintenance. The Director of this Department should not have the right to engage in private practice or to hold any other paid position in the State Government.

* * * * *

E. *Boards of Trustees*

The Commission recommends the establishment of a Board of Trustees for each institution or group of institutions listed in this paragraph. In the last seven years there have been four directors in control and supervision of these State Welfare Institutions. In the last seven years there have been four superintendents of the Mental Hospital. The Commission is of the opinion that a Board of Trustees for an institution, appointed by the method to be recommended (see Appendix VI) will serve to make the administration of an institution more permanent and will have for its primal duty to see that the institution provided by the public fulfills its purpose and needs; and in the exercise of its functions, to be outlined, will act as representatives of the public in the general administration of the institution. There shall be six Boards of Trustees appointed as follows: for (1) The State Hospital for Mental Diseases; (2) The John Clarke Hospital and Medical Center; (3) the Gleason School and Hospital at Exeter; (4) the State Hospital for Tuberculosis; (5) the State Prison, Jail and Reformatory for Men and the State Prison, Jail and Reformatory for Women; and (6) the Whittemore School for Boys and the Harriet Ware School for Girls.

The Commission, therefore, recommends appropriate legislation to accomplish the above mentioned purpose. Such legislation, modeled after a

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law now in force in the State of New York, is found in Appendix VI. The Commission recommends its adoption.

F. State Medical Center

1. *Clinics for Chronic Diseases.* The Commission recommends as a part of the John Clarke Hospital and in the building now known as the State "Reformatory for Men" the establishment of a Medical Center. This Medical Center is to be a unit of the John Clarke Hospital. The rules and regulations of this Medical Center to be made according to law by the superintendent of the John Clarke Hospital, subject to approval in a general way by the Director of the Department of Public Welfare Institutions and the Board of Trustees of this Hospital. In this Medical Center there shall be established under the supervision and control of the superintendent research clinics and special clinics. These clinics shall contain (a) a clinic for the study and treatment of patients of the John Clarke Hospital who are suffering with cancer; (b) a clinic for the study of patients who are suffering from chronic arthritis; (c) a clinic for the study of chronic nervous diseases; and (d) such other clinics as may be established by the superintendent of John Clarke Hospital. The purpose and aim of these special clinics is to group together patients of the John Clarke Hospital into the Medical Center for special study and treatment. Patients of this Medical Center are to be admitted to the John Clarke Hospital and at no time directly into this Medical Center without being admitted to the John Clarke Hospital in accordance with its rules and regulations for admission.

2. *State Juvenile Study Clinic.* There shall also be established by the superintendent of the John Clarke Hospital, with the approval of the Director and Board of Trustees, a clinic to be known as the "State Juvenile Study Clinic." This Clinic shall receive male and female residents of Rhode Island who are not over eighteen years of age and who are suffering from disease or disorder of body, mind and conduct. Admission shall be made according to the rules and regulations made by the superintendent of the Hospital and the laws of the State. This Clinic shall have the power and right to retain a person admitted or committed, for a period not in excess of 28 days. Studies are to be conducted, diagnoses made, records to be kept, and recommendations given as to placement, treatment, and education. The Juvenile Study Clinic shall have for a staff, a physician in charge and as many physicians, psychiatrists, psychometrists, social

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SULFONAMIDES IN THE TREATMENT OF THE COMMON DISEASES OF THE UPPER RESPIRATORY TRACT

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azine therapy in patients with beta hemolytic streptococcal infection of the upper respiratory tract.

What of the pneumococci, influenzal bacillus, and staphylococcal carriers? We have no data on them. There is some evidence, although not conclusive, that sulfadiazine is effective in eliminating meningococcus from the nasopharynx in meningococcal infection. During the past 15 months, 385 cases of meningococcal meningitis and septicemia were treated at the Charles V. Chapin Hospital and only two patients had positive cultures taken before their discharge from the hospital, but the next cultures were negative. Allowing for errors in taking the cultures and in plating them, the result still remains interesting.

One point which is of importance with respect to prophylactic treatment is that the dosage of the drug is more than likely small and inadequate which, if anything, enhances the tolerance of the organisms instead of destroying them.

Thus, the sulfonamides are invaluable in certain bacterial diseases and, when used wisely, are most effective. Their indiscriminate use serves no purpose and may rob the patient of a life-saving measure in his time of need. In diseases of the upper respiratory tract, the sulfonamides are not usually required.

THE SULFONAMIDE TREATMENT OF RESPIRATORY DISEASES IN CHILDHOOD

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tinued value. There is enough accumulated evidence to show that they may be given in small doses over long periods with a minimum of danger. When I say a minimum, I mean that there is still some danger; and certain patients are seen whose reactions are severe enough to indicate the discontinuance of the drug. Doctor Thomas of Baltimore feels that it is safe to give these patients about a gram a day and not follow them unless toxic symptoms appear. In my opinion, it seems that patients receiving such treatment over long periods of time should be seen at intervals in order to determine how they were reacting both as far as beneficial effects are concerned and also as to possible drug toxicity, particularly depression of the blood forming organs.

It is a little difficult to understand the variation in the reports of the frequency of drug toxicity in different groups of patients. Some good observers

say that they are so infrequent that they have no dread of them. Other equally good observers feel as I do that all patients receiving these drugs over long periods should be examined as above indicated."

¹Cecil, Russell L. et al, Jour. A. M. A. Jan. 1, 1944, "Sulfadiazine in the Treatment of the Common Cold".

²Editorial Jour. New England Medical Dec. 9, 1943.

³Bowers, Wesley C., Jour. A. M. A. July 20, 1940, "Observations on 793 Cases of Purulent Otitis Media".

⁴Fink and Wilson, Jour. Pediatrics May, 1943.

⁵Jour. A. M. A. Jan. 22, 1944.

ACUTE RESPIRATORY DISEASES

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although a high count usually suggests that bacterial infection is present and that sulfonamides should be used. We have, however, frequently seen normal and even low counts in proved pneumococcus pneumonias and leucocytosis of a moderate degree in patients who resisted sulfonamides and in whom the evidence strongly favored a virus infection. The older the patient the less one should be inclined to sulfonamides and the more care should be given to an adequate intake of fluid and alkalis. The same is true of patients in whom a suspicion of renal disease exists. The younger the patient the more freely the drug may be used. In really doubtful cases where the physician believes that the condition is, or is likely to become, serious and in which the objection of age or possible renal disease is not present a vigorous therapeutic trial of the drug should be made. In these, and in fact in almost all instances in which there is not a very definite improvement after 48 to 72 hours on the drug, particularly if chemical studies have shown that a good blood level has been attained, the drug should be stopped. It also goes almost without saying that the appearance of any of the well known untoward results of drug action such as anaemia, leukopenia, severe rash or fever, or suppression of urine indicates immediate discontinuance.

Choice of Drugs

The drugs of choice, I believe, are sulfamerazine and sulfadiazine. In our clinic we have apparently been unable to attain any higher blood levels with the former than with the latter. In the severe cases 5 grams of the sodium salt should be administered intravenously and treatment by mouth, one gram every four hours, begun at the same time. We are accustomed to use one teaspoonful of sodium bicarbonate (7 to 8 grams) dissolved in one-half

glass of water with each oral dose. This has resulted in a urinary pH of from 6 to 10 in most of our patients. The blood level determined after eighteen hours or so is a help in controlling treatment and we believe that in some instances recurrence of fever has taken place while the drug is still being administered because, due to infrequent dosage, a level of not over 5 or 6 mg. has been obtained. This has been noted in the use of sulfamerazine in doses of one gram every eight or even every six hours as recommended by the manufacturers and we have recently been using it as we do sulfadiazine at four hourly intervals. In the average patient in whom a prompt fall in temperature has taken place it is well to omit the drug after 48 hours of normal or nearly normal temperature.

In pneumonia, even though the case is typical and the indication for sulfonamide treatment clear, it is very important, if possible, to obtain sputum and blood culture before the drug treatment is under way. If this is not done it is usually impossible, after treatment has gone on for several hours, to find a typable pneumococcus in either blood stream or sputum and therefore the use of the proper serum, which in the occasional severe or drug resistant patient may be needed, is impossible.

Indiscriminate Use Condemned

The indiscriminate use of sulfonamides without adequate study of the patient is to be condemned. It has been urged that by their use in virus-caused disease bacterial complications may be prevented. This may be so to a limited extent if large doses of the drug are used for a long enough time, but, in my judgment, the possible harmful effects of these drugs, including renal block, blood changes, nausea, vomiting, rashes and drug fever are greatly outweigh such theoretical advantages. It also must not be forgotten that repeated small and ineffective doses of the drug in the presence of a susceptible organism, tend to render that organism resistant so that the later use of adequate doses will be no longer effective. It is quite possible that if, as the years go on, the drug is widely used in insufficient dosage, a large number of highly resistant strains of pneumococci and other organisms will survive in the community and we will be faced with outbreaks of pneumonia in which as far as sulfonamide treatment is concerned we may find ourselves helpless.

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WELFARE COMMISSION REPORT

In this issue of the JOURNAL is reprinted the general recommendations of the State Commission on Public Welfare Institutions as regards the medical care institutions. This phase of the report warrants the attention of every doctor of medicine in the State. The work of the Commission has been excellently done, and it is to be regretted that the conclusions it has reached have been lessened in general public understanding of them by the filing of two minority reports by members of the Commission.

The Commission had a three-fold purpose. It was created to appraise existing conditions in the State institutions; it was to determine what might be done immediately towards relieving conditions; and it was to recommend a long-range plan for institutional improvement. The long range planning will necessarily be subject to a great extent to post-war problems as well as the strength of the political leadership of the State in the years ahead. But certainly there should be no delay in relieving some of the present conditions which the clear-cut and sharp appraisal of the non-partisan Commission has revealed.

For too long the idea has persisted that the problem of the state institutions is solved by merely appropriating annually funds which provide for

what amounts to minimum maintenance and operation of the establishments. Too long has the interest in the structure of the physical plans overshadowed the work which should and must be done for the unfortunate patients or inmates whose good care rests upon the humanitarian viewpoint of our citizens.

While certain recommendations of the Commission, such as the proposal to create a separate Department of Public Welfare Institutions, may be debatable, they certainly should not be allowed to hide from the view the basic issue revealed by the study. That issue, as we see it, is the provision by appropriation of public welfare funds and otherwise whereby adequate salaries and good housing conditions may be offered to attract highly specialized professional individuals to implement our institutional staffs. A careful study of the State budget by the General Assembly with this thought paramount might well relieve to some extent the present conditions.

With strong professional leadership, employed under civil service regulations and independent of the changes in state political administration, our state institutions might well achieve their true purposes according to highest standards. Otherwise, as the Commission so well states in its report, "the fine buildings and equipment, frequently added to at

great public expense from year to year, in which the individual services to the unfortunate patients or inmates are so poor . . . due to lack of trained personnel . . . from a public welfare standpoint are mere hollow shells."

THE BAR ASSOCIATION ON THE WAGNER ACT

For the past eight months the medical profession of America has militantly led the fight against the proposed Wagner-Murray-Dingell act now before Congress. In this legislation the doctors of the nation noted the effort to encroach on the right and liberties of the citizens with the pretext of improvement of the general health of all as the lever with which to win support for the act.

The report, therefore, made by the special committee of the American Bar Association to study and report as to parts of the Wagner Murray bill relating to federal control and regulation of medical practice and hospitalization, and subsequently adopted by the House of Delegates of the Bar Association on February 28, stands as an important document worthy of the attention of doctor and patient alike.

The following significant conclusion was made in the complete analysis by the Bar Association Committee:

CONCLUSION

The American Bar Association is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. Under normal circumstances, therefore, it is not the function of this association to attempt to influence substantive legislation by the Congress of the United States. But when under the pretext of the general welfare legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country, it becomes the duty of this association actively to voice its objections, a summary of which is as follows:

1. Local self government must be preserved in our federal system. State governments directly responsible to the will of the people are best adapted to exercise such supervisory control as may be instituted over the health and medical care of our citizens.

2. S. 1161 seeks to invest in the Surgeon General, who is not an elected servant of the people and who is not amenable to their will, the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home.

3. The measure furnishes the instrumentality by which physicians for their practice, hospitals for their continued existence and citizens for their health and that of their families can be made to serve the purposes of a federal agency.

4. The bill fails to safeguard the rights of patients, citizens, hospitals or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.

5. The bill fails to provide for any appeal to any court from the action of the Surgeon General.

6. The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government and incompatible with the adequate protection of the liberties of the people.

The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear on them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates.

CASH SICKNESS COMMITTEE

The appointment within the past month by Dr. M. H. Sullivan, president of the State Society, of a 10-member Advisory Committee to the state Unemployment Compensation Board to assist in the medical phases of the state Cash Sickness Act should go far towards the solution of some of the existing medical administrative problems of this program.

It is unfortunate that such an advisory committee was not sought by the UCB a year ago. Certainly there was evident cooperation from the start on the part of the medical society leaders, for the presidents of the State Society and the Providence Medical Association in 1942 met with the Board when

the act was first made law. Subsequently the Committee on Medical Economics and the officers of the State Society met with the Board in December, 1942, to review the entire program and to proffer assistance.

With the actual operation of the distribution of benefits on claims for sickness the Board encountered many difficulties of a medical nature which might have been avoided. Failure to include representatives of the State Medical Society in the planning only aggravated a condition which was highlighted by controversy in the daily press last fall. Now that the Board has extended the invitation to Dr. Sullivan to name a statewide committee to assist in an advisory capacity we may hope for a better understanding and a better interpretation of rulings, for the benefit of the workers whose contributions make the disability insurance plan in Rhode Island the only one of its kind in the country.

PORTRAITS OF PAST PRESIDENTS

Editor, Rhode Island Medical Journal:

In the spring of 1943, when Dr. Elihu Wing made the admirable suggestion that we have a portrait painted of our then president, Charlie Gormly, he started a precedent which I think should be continued.

We have always had some fine men as presidents of our state society, and they should likewise be honored, even though many of our past presidents still in active practice might in their modesty be reticent concerning such a procedure. How retroactive this should be remains within the discretion of the society members, but surely those who are living and most assuredly the two men, Fred Hussey and Murray Danforth, who left us last June should be included. Did anyone in this society ever see such courage as that displayed by Murray Danforth, when he arose from his bed to give his short inaugural address at the annual meeting two days before his death? He, himself, must have known that his end was near, but unflinching and devotedly as he lived his life, so he carried on to the end. He was world known as an orthopedist.

We have had surgeons of national note, anesthesiologists known throughout the country, a cardiologist whose work and writing have added much to our knowledge, medical men whose very lives have demonstrated their worth, men perchance who added little to medical literature but whose ac-

complishments in the community were sufficient guarantee of their virtues.

Certainly there are some families of our past presidents who would unquestionably be glad to contribute a portrait, but in lieu of such a gift, surely by contribution of members enough could be raised to have portraits painted from photographs. This procedure is most satisfactory, the cost is slight, the likeness always the best and such portraits can be painted in a size of 18" x 24", requiring very little wall space in our library and auditorium.

At a recent meeting of the House of Delegates the suggestion was made that what remained from the contribution fund for Dr. Gormly's portrait should be donated to an award for the physician who in the future is chosen to deliver the Charles V. Chapin lecture at the annual state society meeting. I for one would rather have had this sum used for the purpose mentioned in this communication. The medical society itself should furnish from its own treasury the money necessary for the honorary award to the future speakers at our annual meetings. Every member of our society profits by such a lecture, all are interested and should contribute to the cost when paying their dues. The speaker should not be remunerated by our subscriptions to a fund. There are those of us who would be willing to give to cover the cost of portraits of those past living presidents or of those who have left our midst, but later when this task of catching up is over, the society should assume, through its treasury, the cost of painting the portrait from life or from photograph of each future president.

While we are on the subject of honorary portraits, what about some of our secretaries? There is a framed set of resolutions at the right of our coat room to Jim Leech who for twenty years gave his thought, time and withal devoted patience to the affairs of our society. If ever a member of our society deserved a portrait, it is Jim Leech. It should be placed in a conspicuous place with the resolutions beneath.

Since I have known your present secretary he has been devotedly interested in every activity of this society, has given unstintingly of his time, his labor, his knowledge and administrative ability, often to the detriment of his private practice.

Our presidents serve for one year only, our secretaries work on for years, but such is the scheme of life that they go unhonored for their labors.

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ADULT DENTO-FACIAL REHABILITATION

MORRIS RUMLER LEBOW, D.D.S., Providence, R. I.

THE old adage, "For want of a shoe the horse was lost," may be modernized to, "For want of a tooth all teeth were lost." This sounds like an overstatement; nevertheless it is true. The late Dr. Martin Dewey, a well-known teacher in the field of orthodontics, once remarked that if he had an enemy and wanted to wish him harm, he would wish him to lose one tooth and then let him loose. This enemy would have enough trouble to take care of him for the rest of his life. I questioned the truth of that statement at that time, but after examining some human skulls, together with a life time of clinical observations, I arrived at the same conclusion.

The average layman believes that his permanent teeth are only temporary, and that it is a matter of time only before they are all lost. Nothing could be farther from the truth. As a matter of fact, nature did not intend permanent teeth to be temporary, but to last during an individual's life time.

The question comes to the mind, what happens when a tooth is lost? The answer may be better understood if we compare the human dentition with that of a wooden barrel. Both the dentition and barrel are held together in a similar manner. The wooden barrel is made up of staves which are held together by its contiguity of the staves and by the hoops. If one of the hoops is lost and a stave falls out the entire barrel collapses. In a similar manner the human dentition is made up of individual teeth which are held together by contiguity. The tongue, cheeks, and lips help to keep them in position. When a tooth is lost and is not immediately replaced by an artificial pontic, there begins to take place a movement of all teeth affected into malposed positions, and finally a malocclusion is thereby

created. This is where the vicious circle begins which may finally end with the loss of all teeth. Any artificial dental restorations placed upon these malposed teeth must inevitably end in failure. This is often the reason why some of our best efforts do not succeed. It does not make any difference whether it be a partial plate, a fixed bridge, or a removable bridge, if the cause or the malocclusion is present, it will definitely end in failure.

For a number of years I have taken on some adult cases for orthodontic correction with the idea of preparing them for dental restoration. By that I mean that I have corrected abnormal occlusions for adults in preparation for dental restoration. Invariably this treatment was more than a success, satisfactory to dentist as well as to the patient.

Recently I have demonstrated some of these results before the Rhode Island State Dental Society. One case shown was completed fourteen years ago and is still going strong; another was completed eight years ago. Every tooth is still there with no gingival involvement. One case, a woman of thirty-two, manifested a bad case of gingivitis. The correction of the malocclusion also corrected that condition, requiring but minor medication. Another case, a woman twenty-eight years old, with missing molars of both jaws, manifested an extreme maxillary protusion. The protusion was corrected, her dentist replaced the missing molars, and we have restored a very bad mouth to normal usefulness, both from the aesthetic and the utility point of view. This woman showed up two years after completion. She is a most satisfied and grateful patient.

Conditions which require some orthodontic corrections are many and varied. They may vary from

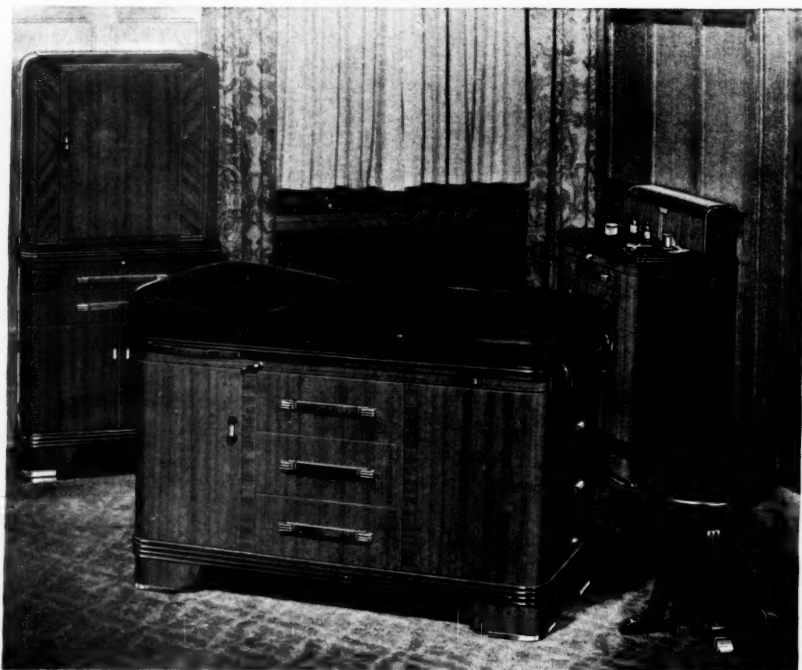
continued on page 127

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ADULT DENTO-FACIAL REHABILITATION

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large spaces formed in the incisor region of the mandible, displaced molars, spaced maxillary incisors, unerupted canines and premolars to a gross malocclusion of all teeth. Proper dental restoration calls first for immediate restoration of teeth which have been lost by extraction; secondly, when teeth have shifted into malposition, it calls for orthodontic correction before dental restorations are undertaken. Adult orthodontics must of necessity be limited as to both its scope and to its time of treatment. One cannot expect an adult to wear appliances for a number of years as is often the case with juveniles.

One of the benefits not ordinarily recognized is the fact that orthodontic procedures induce the breaking down of the old alveolar process which in turn is replaced by a new one. The final and beneficial result is a new alveolar process supporting old teeth in an older person. If we could only rebuild our hearts and blood vessels in the same manner as we do the alveolar process, what a boon it would be for mankind!

Conclusions

1. Teeth lost by extraction must be immediately replaced. This is to prevent the dentition from lapsing into malpositions.
2. Adult orthodontics is practical, irrespective of age.
3. Limited orthodontics is indicated in some cases as a preliminary treatment for successful dental restorations.
4. Orthodontic procedures rebuild the alveolar process and invigorate the supporting structures of the teeth.

* * * * *

COMMITTEE APPOINTMENTS FOR 1944

ANNOUNCEMENT of the appointments to serve on the committees of the State Dental Society for 1944 has been made by President Arthur M. Dring as follows:

COMMITTEE ON DENTAL ETHICS AND DEPARTMENT

Dr. F. H. Ackrill, Chairman, Providence; Dr. R. L. Webster, Providence; Dr. E. C. Morin, Pawtucket; Dr. C. F. Cannon, Providence; Dr. A. A. Albert, Pawtucket; Dr. T. N. Panaretos, Pawtucket; Dr. J. F. Keighley, Providence; and Dr. G. J. Denicourt, Cranston.

DENTAL-MEDICAL COMMITTEE

Dr. M. A. Denby, Chairman, Warren; Dr. C. J. Smith, Providence; Dr. E. Gill, Providence; Dr. F. J. Canning, Providence; Dr. I. G. Schaffer, Newport; Dr. M. R. LeBow, Providence; and Dr. I. O. Atwood, Providence.

COMMITTEE ON DENTAL LEGISLATION

Dr. A. A. Albert, Chairman, Pawtucket; Dr. P. J. Conley, West Warwick; Dr. T. W. Clune, Cranston; Dr. D. C. Dove, Westerly; and Dr. E. A. Lynaugh, Pascoag.

COMMITTEE ON ORAL HYGIENE-PUBLIC HEALTH

Dr. H. McKanna, Chairman, West Warwick; Dr. T. W. Clune, Cranston; Dr. F. A. Corbett, Newport; Dr. H. J. Pearce, Providence; Dr. A. J. Kershaw, West Warwick; Dr. L. E. Deslandes, Providence; and Dr. B. C. Friedman, Newport.

COMMITTEE ON THE PRESIDENT'S ADDRESS

Dr. E. B. Keighley, Chairman, Pawtucket; Dr. W. S. Gee, Jr., West Warwick; and Dr. A. Johnston, Warren.

*continued on page 143***PROTECTION for
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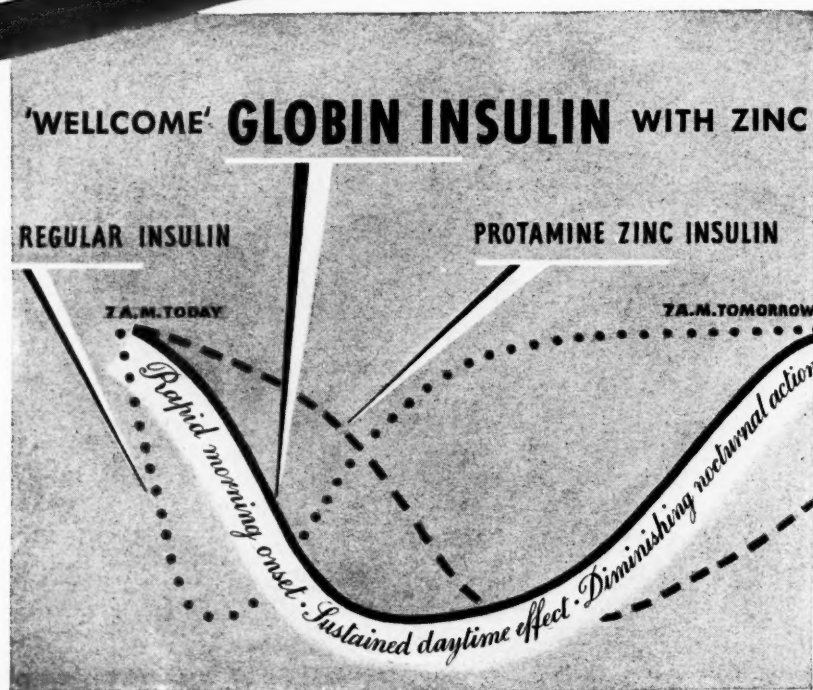
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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

THE attention of all physicians in Rhode Island is again called to the form of Certificate of Availability reproduced elsewhere in this issue.

It is essential for physicians to completely fill out all parts of this blank. We fully realize these details add an additional load of paper work on an already overburdened physician, but it also takes the responsibility of deciding whether or not the patient is entitled to a change of job off the physician's shoulders. All the physician has to do is to state the case honestly and fairly. Then the patient's welfare is in the hands of the War Manpower Commission.

We have been commended by the American Medical Association and other states for the form. This method of handling the medical aspect of the certificate of availability has received favorable comment from government officials in Washington, as well as medical societies throughout the country who have asked to see copies of this blank. Your cooperation is earnestly solicited.

INDUSTRIAL HEALTH CONFERENCE

The Sixth Annual Congress of Industrial Health was held at the Palmer House, Chicago, February 15th and 16th. Rhode Islanders in attendance were Drs. Charles Farrell, Robert T. Henry, and James P. Deery. That Industrial Medicine is assuming a more and more important place in medical practice was clearly evidenced at this meeting. Papers and discussions covered a range of subjects from the field of preventive medicine to the consideration of post-war industrial health. Newer developments in occupational medicine were discussed and plans for an Institute of Industrial Health at Wayne University were outlined in detail. This is indeed an ambitious undertaking. A further and full report should be available soon. A visual service for small manufacturing plants was given consideration along with the conquest of tuberculosis in industry. The relationships of medicine-labor-management in industry in harmonious cooperation was reported from Philadelphia. Nearly every phase of Industrial Medical practice from malnu-

trition to newer developments of workmen's compensation disability evaluation was discussed. One of the most interesting symposiums of the meeting was that regarding the rehabilitation and re-employment of the disabled. Everybody who attended felt that this was really a first step forward.

Following the American Medical Association Council of Industrial Health meeting in Chicago, the New England Conference of Industrial Physicians and Surgeons had their regional conference in Boston on February 23rd. Drs. John Kenney, Stanley Sprague, Robert T. Henry and James P. Deery attended from Rhode Island.

RHODE ISLAND ANNUAL MEETING

The Annual Meeting of the Rhode Island Society of Industrial Physicians and Surgeons will be held at the Rhode Island Medical Library on May 23, 1944, just one day previous to the Meeting of the Rhode Island Medical Society. Featured speakers have already been engaged and plans for an elaborate program are well under way. Mark the date on your calendar now!

OFFICIAL RECOGNITION GIVEN

The Rhode Island Society of Industrial Physicians and Surgeons has been accepted as a section of the New England Conference of Industrial Physicians and Surgeons. This means that the active members of the Rhode Island Society who are eligible for full active membership in the New England Conference automatically become members of the American Association of Industrial Physicians and Surgeons through the component Society. Those of the group in the Rhode Island Society who have not been in industrial practice for three years, or have not been out of medical school for five years, or who do not do fifty per cent of their work in industry, will be eligible for an Associate membership in the New England Conference. Further details will be presented at the next meeting. The important fact is that we are now affiliated with the American Association

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OFFICIAL RECOGNITION GIVEN

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of Industrial Physicians and Surgeons through the New England Conference which is a component Society of the national organization.

The 1944 Meeting of the American Association of Industrial Physicians and Surgeons will be held in St. Louis, May 11th to 14th, at the New Jefferson Hotel. The American Association of Industrial Nurses will hold sessions May 12-13 and 14th. The New Jefferson Hotel is official headquarters and reservations should be made early.

USE OF COLD VACCINES

The American Medical Association reports that there is an increase in the prescription and sale of cold vaccine. It is important to remember that there is no recognized scientific evidence of the value of these preparations. Industrial physicians should exercise care in the promiscuous prescribing of cold vaccines. An excellent article appears in the February 26, 1944 issue of the Journal of the American Medical Association, page 555, by McGee, Andes, Plume, and Hinton.

PORTRAITS OF PAST PRESIDENTS

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always much more intense than that demanded of our presidents. I offer this suggestion, Mr. Editor, with the whole-hearted fervor of one who never expects to be the president of the Rhode Island Medical Society. We are indeed a busy and consequently an unemotional group. Let's stir up our sentiment a bit. It is a good tonic for the soul.

Respectfully yours,

HENRY E. UTTER, M.D.

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FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street

Providence

MEETING OF HOUSE OF DELEGATES

At the January meeting of the House of Delegates, held at the medical Library on January 27, the following actions were taken:

ANNUAL MEETING: The dates for the 1944 annual meeting of the Rhode Island Medical Society were officially set for Wednesday, May 24 and Thursday, May 25, the sessions to be held at Providence.

C. V. CHAPIN ORATION FUND: The report of the Committee on the Charles V. Chapin Oration Fund was received and placed on file. The Committee was also empowered to act to accumulate the sum of money suggested by its proposal.

DELEGATES TO THE A. M. A.: The House unanimously elected Dr. Alex M. Burgess of Providence as its delegate to the House of Delegates of the American Medical Association, and Dr. William P. Buffum of Providence, as alternate delegate.

APPOINTIVE COMMITTEES: The House adopted the recommendation of the Council that the Appointive Committees of the Society be named at the time of the Annual Meeting to serve for the ensuing 12 month period, and that the present appointive committees be continued in office until May, 1944.

INDUSTRIAL PHYSICIANS MEETING: The House voted that the Rhode Island Society of Industrial Physicians and Surgeons be allowed the use of the Medical Library building for the day preceding the Annual Meeting of the Rhode Island Medical Society—Tuesday, May 23—for the purpose of holding the annual meeting of that organization.

VOLUNTARY HEALTH COUNCIL: After lengthy discussion of the proposal for a statewide voluntary health council the House moved the approval of the proposal made by Dr. Emery M. Porter for a statewide Voluntary Health

Council as outlined by him in his address to the Providence Medical Association, and further, the House "acquiesced" in the Governor's suggestion that he appoint the Council.

The House also adopted a motion that the Society's representatives on the Voluntary Health Council report to the House of Delegates at stated intervals as to the progress made in the studies.

MEDICAL CARE OF INDIGENT: The report of Dr. Peter F. Harrington, chairman of the Committee on Public Welfare, relative to a plan put into operation by the state department of social welfare in East Providence on a trial basis, was accepted and placed on file.

RED CROSS AGREEMENT

Gentlemen:

The Home Service Department of the American Red Cross is constantly in touch with many of your members, asking for verification for the need for emergency furlough in servicemen's homes when there is serious illness.

In behalf of the Department I wish to extend my sincere appreciation for the courtesy and consideration which you give the members of this Staff in answering their many calls. We know that this is an added burden in your very busy lives. On the other hand, it is the only means of enabling a soldier to come home when there is serious illness in his immediate family.

It has been brought to my attention that many times servicemen's families and the servicemen themselves are in need of medical attention; the Red Cross would appreciate having some agreement with the Rhode Island Medical Society, so that when we authorize a family to call in a doctor of their own choosing, that the doctor will feel free to bill us for his services. As we understand it there is a similar agreement with the Department of Public Welfare and we believe their charges are \$2. for an office call and \$3. for a home visit.

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The JOURNAL publishes below a list of the members of the Rhode Island Medical Society who are serving with the armed forces of the United States. Every effort has been made to make this list complete and accurate. However, there is likelihood of error due to changes in commissions of which we are not informed. The JOURNAL urges that its readers notify it of any corrections or additions to this list so that subsequent displays may be accurate, and also that the official records of the Society may be complete. . . . *The Editors.*

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DISTRICT SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

The annual meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday night, February 1, 1944, at 8:30 P. M. Dr. Louis E. Burns, President, presided. There was no unfinished business.

Dr. Charles Dotterer reported as a delegate of the recent meeting of the House of Delegates in Providence on the proposed Medical Health program in the state, and the Governor's report on the proposed Health Council. The communication was received.

Election of officers for the ensuing year resulted in the following members being elected:

President.....	CHARLES S. DOTTERER, M.D.
1st vice-president.....	WILLIAM A. STOOFS, M.D.
2nd vice-president.....	ALFRED M. TARTAGLINO, M.D.
Secretary.....	PHILEMON P. CIARLA, M.D.
Treasurer.....	NORBERT U. ZIELINSKI, M.D.
Delegates.....	{ JAMES CALLAHAN, M.D. SAMUEL ADELSON, M.D.
Councillor.....	NORMAN MACLEOD, M.D.
Censors.....	{ DOUGLAS JACOBY, M.D. JOHN A. YOUNG, M.D.

Dr. Burns introduced the speaker of the evening, Lt. Comdr. Wesley Buddington, MC, USNR, who chose as his subject, "Management of Common Urological Problems." The highlights of his presentation are summarized as follows:

Renal Calculi often results in much pain, and is often a real emergency; these calculi usually start in the kidney and very often lodge in the ureter. Due to the disproportion of the stone to the lumen of the ureter there is a contraction of the smooth muscle and consequent pain.

Urine is a watery solution of colloids and crystalloids. The nucleus of the calculi starts with the salts of the urine. Due to stasis, there is a precipitation of these salts which occurs faster than would happen when there is a smoothly running stream of urine. Another cause is infection, as from a streptococci throat, toxins being excreted through the blood stream, and excreted in the urine forming a local infection of the kidney tract as in pyelitis, etc. Calculi can also be caused by a hyper-excretory condition with an excess of calcium, etc., being thrown off in the urine as would occur in cases

of parathyroid diseases. Another common cause is sulfonamide therapy. It can also be caused by avitaminosis, usually due to a lack of vitamin A which inhibits the epithelium of the urinary tract.

Diagnosis. RENAL CALCULI.

1. This is usually easy. Pain very often radiates down the flank to the bladder and sometimes to the legs and loins. In some cases, however, the pain may be confused with infectious conditions of the chest and be mistaken for a pulmonary condition.

2. Gastro-intestinal type which begins with nausea, vomiting, abdominal distention with fever, the patient being very tender over the kidney area.

3. X-ray is the most useful item as most of the stones will show.

4. Intravenous pyelogram. This is very helpful, but, however, they should not supplant cystoscopy.

5. Cystoscopy. A very important procedure.

6. Careful urine examination, including cultures, etc.

Treatment

A patient with renal calculi should never be dismissed. It is not always necessary to remove all stones but patient should be watched for possible kidney damage.

1. Morphine sulphate and atropine hypodermics for relief of pain very often moves the stone and urine gets through. The speaker does not believe in so-called morphine anuria or reflex anuria. In cases where this occurs it is well to check for possible stone obstruction in other kidney tract.

2. Fluids are very important as an adjunct as they control infection and relieve patient. 3000 to 4000 c.c. daily given parenterally.

3. Every one or two days it is well to do an I. V. pyelogram if the symptoms persist. Next a cystoscopy should be done. The catheters may be left in the ureter thus often giving relief by promoting drainage.

Later Treatment

1. Operative.

Urethral dilation very often helps.

Reasons for Operation.

1. To relieve persistent pain.

continued on next page

2. Persistent hemorrhage.
3. Infection behind the stone.
4. Loss of renal function.

If the patient is properly treated kidneys come back a great deal after pressure and infection are controlled.

"Dissolution of stones" method is not of much value as a rule, but there is a preparation called Sol. G. which in the hands of some operators has had some success in so far as this solution is less irritating to the ureter. Kaiser improved upon this solution by using urea solution with the Sol. G. alternately and thus was able to dissolve more stones.

Other Treatment

Diets help to prevent further calculi. Use either acid ash or alkaline ash, depending upon the type of stone found.

The most important single thing for preventing recurrent calculi is a high fluid intake for life as soon as the ureters are free.

The speaker mentioned a few words on the use of penicillin in infections resistant to sulfonamides, particularly in the case of specific urethritis; and a series of about 30 cases giving 20,000 units intramuscularly every four hours for five doses, he had no known failures.

There was a general discussion following the presentation in which most of the members took part.

The Society was honored in having Capt. Mills, MC, USN., Commandant of the Newport Naval Hospital, present as a guest. Capt. Mills expressed his pleasure at being present and he participated in the discussion.

A rising vote of thanks was extended to the speaker.

The meeting adjourned at 10:35 P. M., and a collation was then served.

ALFRED M. TARTAGLINO, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The monthly meeting of the Pawtucket Medical Association was held at the Memorial Hospital on Thursday, February 17.

Vice-president Edward Trainor presided. The report of the nominating committee was read by Dr. James L. Wheaton, chairman. The following slate of nominees was presented:

President—Edward H. Trainor, M.D.
Vice-President—Orland F. Smith, M.D.
Secretary—William N. Kalcounos, M.D.
Treasurer—Laurence A. Senseman, M.D.

RHODE ISLAND MEDICAL JOURNAL

Standing Committee—Armand Bertini, M.D.

Councillor—James L. Wheaton, M.D.

Delegates—J. Lincoln Turner, M.D.

Stanley Sprague, M.D.

Walter J. Dufresne, M.D.

Earl J. Mara, M.D.

Election of officers will take place at the Annual Meeting which will be held next month. The following committee was appointed to take charge of this meeting: Dr. Robert T. Henry, chairman, to be assisted by Dr. Walter J. Dufresne and Dr. Armand A. Bertini.

MARY-ELAINE J. ROHR, M.D.

PROVIDENCE MEDICAL ASSOCIATION

A joint meeting of the Providence Medical Association and the Rhode Island Medical Society was held at the Medical Library on Monday, February 7, 1944.

Dr. Albert H. Jackvony, presiding officer, announced that the reading of the minutes of the previous meeting would be omitted unless there was objection to such action.

The Secretary read a communication from the Rhode Island Nutrition Association and also a communication from Brown University announcing the Sigma Psi lecture on the "Modern Treatment of Burns" to be given by Dr. Aldrich of the Boston City Hospital on March 13th.

The Secretary reported for the Executive Committee as follows:

1. The Annual Report of the Medical Milk Commission of the Association audited by a professional auditing service, was accepted and placed on file.

2. The Committee moved that the Association not hold a case report contest during 1944 because of the fact that the internes are serving limited time at the hospitals and are burdened with much work.

3. The Committee moved that the resolution passed by the Association at the January meeting relative to the exclusion of certain medical services from any hospitalization contracts should be re-submitted to the House of Delegates of the Rhode Island Medical Society at its meeting in May.

4. The Committee moved to recommend to the Association that it purchase from its operating fund a United States Treasury Certificate in the amount of \$1,000 in the name of the Providence Medical Association.

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DISTRICT SOCIETY MEETINGS

continued from page 138

The report of the Executive Committee and the recommendations therein was adopted.

The Secretary reported that the Executive Committee recommended for election to active membership Dr. Arthur B. Cuddy and Dr. Israel Kapnick. Both applicants were unanimously elected.

The President announced that he had appointed Dr. Louis I. Kramer and Dr. Ezra Sharp to prepare the obituary tribute to the late Dr. Irving Blazar, and Dr. J. J. Vallone and Dr. George Dwyer to prepare the tribute to the late Dr. George Mankis.

The President announced that representatives of Winthrop Chemical Company, Eli Lilly & Company, Smith-Holden and the Parke, Davis Company were present with exhibits in the reading room by invitation of the Providence Medical Association, and he stated that the representatives of these companies would be pleased to discuss their products with any doctors after the meeting.

The business of the Providence Medical Association being completed, Dr. Jackvony adjourned the session so that the Association might join with the State Medical Society in its annual mid-winter meeting.

Dr. Michael H. Sullivan, President of the Rhode Island Medical Society, introduced the speakers for the scientific presentation which was a panel discussion on "Acute Diseases of the Respiratory Tract", under the chairmanship of Dr. Alex M. Burgess. The other members of the panel discussion were Dr. Henry E. Utter, Dr. Kalei K. Gregory, and Russel O. Bowman, Ph.D., Biochemist at Rhode Island Hospital.

Attendance 115. Collation was served.

FRANK W. DIMMITT, M.D., *Secretary*

FROM THE SECRETARY'S DESK

continued from page 132

If this arrangement is satisfactory to the Rhode Island Medical Society, we would like to establish it as a policy.

Very truly yours,

JOSEPH H. GAINER,

JHG:GG

Home Service Chairman.

(At the January meeting of the council of the Rhode Island Medical Society official approval was given to the arrangement suggested in the above

communication from the American Red Cross. All members of the Society are urged to cooperate in this plan of the Red Cross to assist in the payment of medical care for the needy families of servicemen.)

APPRECIATION FROM DETAIL MEN

Dear Mr. Farrell:

At a recent meeting of the Traveling Men's Auxiliary of the Rhode Island Pharmaceutical Association it was voted to have the Secretary send a letter of thanks and appreciation to the Rhode Island Medical Society for the many courtesies extended to our members during these busy days.

Our organization is composed largely of representatives of the various pharmaceutical manufacturers and all of us, in our daily contacts with physicians, have become fully cognizant of the increase in the number of patients and the consequent increase in demands made upon the members of your society for their precious time.

Despite this pressure of time, we have all been graciously received on our visits with your members.

We greatly appreciate this and extend to you our many thanks.

Cordially yours,

NEIL CONNOLLY, *Secretary.*

CASH SICKNESS ACT COMMITTEE

An invitation from the Unemployment Compensation Board to the Society to appoint an advisory committee to advise the Board on medical phases of the Cash Sickness Act was received within the past month. A committee, statewide in representation, was named immediately by Dr. Michael H. Sullivan, and this new committee has already met in conference with the U.C. Board. The personnel of the committee is as follows:

HERMAN C. PITTS, M.D., *Chairman*, 68 Brown Street, Providence.

LUCIUS C. KINGMAN, M.D., 76 Waterman Street, Providence

ALEX M. BURGESS, M.D., 454 Angell Street, Providence

G. RAYMOND FOX, M.D., 209 Broadway, Pawtucket

ARCADIE GIURA, M.D., 31 Washington Street, Warren

ROBERT BESTOSO, M.D., 135 Touro Street, Newport

ROYAL C. HUDSON, M.D., 1225 Main Street, West Warwick

SALVATORE P. TURCO, M.D., 170 High Street, Peace Dale

FERNALD C. FITTS, M.D., 125 West Broad Street, Westerly

JAMES M. MCCARTHY, M.D., 426 Blackstone Street, Woonsocket.

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DENTAL SOCIETY COMMITTEES

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COMMITTEE ON GIES FUND

Dr. E. A. Charbonnel, Chairman, Providence; Dr. A. L. Midgley, Providence; Dr. A. H. Lynch, Providence; Dr. J. P. Massicotte, Providence; and Dr. P. J. Conley, West Warwick.

COMMITTEE ON NOMINATIONS —
RESOLUTIONS

Dr. H. A. Martin, Chairman, Newport; Dr. A. Picard, Woonsocket; Dr. W. F. Harrison, Providence; Dr. E. C. Morin, Pawtucket; Dr. G. J. Racicot, West Warwick; and Dr. H. F. Doyle, West-erly.

COMMITTEE ON DENTAL EDUCATION—
LITERATURE — RESEARCH

Dr. T. MacKnight, Chairman, Newport; Dr. J. L. Baesler, Providence; Dr. E. L. Bessette, Cranston; Dr. M. Tishler, Newport; Dr. J. F. Colgan, Pawtucket; Dr. A. G. Berger, Providence; Dr. H. Mathers, Newport; and Dr. F. P. Duffy, West Warwick.

COMMITTEE ON NECROLOGY

Dr. W. A. Morinville, Pawtucket; Dr. J. J. Clancy, East Providence; and Dr. T. P. Fogarty, Woonsocket.

COMMITTEE ON PUBLICATIONS

Dr. N. Fortier, Chairman, Pawtucket; Dr. C. F. McKivergan, Providence; Dr. A. L. Midgley, Providence; and Dr. W. F. Tompkins, Providence.

COMMITTEE ON CENSORSHIP—
MEMBERSHIP

Dr. P. E. Cote, Chairman, Woonsocket; Dr. R. Stalworthy, Providence; and Dr. W. S. Gee, Jr., West Warwick.

AT THE CHICAGO MEETING

Dr. Norman H. Fortier, of Pawtucket, was Rhode Island's representative at the very successful 80th annual midwinter meeting of the Chicago Dental Society last month.

NECROLOGY

DR. JAMES J. DURKIN of Olneyville
Died, February 10, 1944

DR. ALBERT J. POBIRS of Providence
Died, February 24, 1944



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WELFARE COMMISSION RECOMMENDATION

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workers, school workers, and clerks as necessary. All children before admission to the Gleason School and Hospital and the Whittemore School for Boys and the Harriet Ware School for Girls should be studied in this Clinic whenever this is possible. All cases committed by the courts shall be adequately studied and opinions given but in no case shall any physician or worker in this Clinic be otherwise than a non-partisan witness if called to testify in the case of a person studied in this Clinic and all fees for such testimony shall be paid to the State.

The Policy of this State Juvenile Clinic shall always be for the purpose of study, diagnosis, prognosis, and placement of youthful citizens who are beginning to show evidence of poor health or bad conduct, in the home, on the street, or in the school; or whose condition suggests early mental disorder. In addition to the functions above enumerated, the Clinic shall maintain social-educational and medical interests in the patients who have been studied and placed in the John Clarke Hospital, the Gleason School and Hospital, the Whittemore School for Boys, and the Harriet Ware School for Girls. It is not the purpose of this Clinic to compete with outside physicians or institutions, with problem clinics or child guidance clinics, but to supplement the work of other clinics for more adequate studies.

It is manifest that a State Juvenile Study Clinic under medical supervision is more pertinent to the study of juvenile disorders than one where corrective measures only are suggested. The Study Clinic conducted in accordance with the aims and policies mentioned can be a valuable reference clinic for the twelve District Courts and the five Superior Courts. One of the main purposes of this State Juvenile Study Clinic is to be a help to the Courts. Its work, carried out in the manner suggested, would render the establishment of a separate Juvenile Court unnecessary.

G. Internal Organization—Administrative Councils

The internal administration of every one of our Public Welfare Institutions has been by the "grapevine". Our State Institutions began as farms and developed into medical and correctional institutions, and today the policy appears to be a return to the farms with the "grapevine" as the administrative method within and without. The "grapevine" should be uprooted and a modern internal administrative organization established. This new organization should be departmental with definite

duties and responsibilities. It should be composed of chiefs of the various services.

In every one of our institutions, both medical and correctional, this type of organization should be established, modified according to the purpose of the specific institution in question. By such a definite departmental set-up, an organization quite analogous to that of the State Government with its Departments and Directors will be created. Such an arrangement assures the placing and fixing of responsibility. It also allows mutual aid and cooperation between comparable departments of different hospitals. For example, the clinical director of the State Hospital for Mental Diseases could get very real assistance in the care of his patients who suffer from tuberculosis as a complication (and there are many such) from the clinical director of the Sanatorium at Wallum Lake.

The following organization is recommended:

1. Medical Institutions

a. Executive Officers (Superintendent, Assistant Superintendent, Clinical Director, Business Agent, Pathologist.)

b. Visiting Staff. There should be a visiting staff appointed by the superintendent with the approval of the board of trustees. This staff shall receive a stipend and transportation. The staff should comprise physicians, surgeons, and appropriate specialists. These visiting men should not be mere consultants but should aid in the study, diagnosis, and treatment of patients. This policy of giving the visiting staff greater power and duties than heretofore has been the custom will serve to improve the progress and speed the release of patients. The staff will bring in wide experience gained in general hospitals and continue the treatment of many patients who have previously been studied in other hospitals in the State. In view of the obvious fact that in our State hospitals are patients with chronic diseases, the acute stages of which were in very many instances observed and treated in the general hospitals of the State, it will be of the greatest benefit to these patients to have as members of the visiting staff doctors who are also serving on the staffs of the general hospitals from which they come.

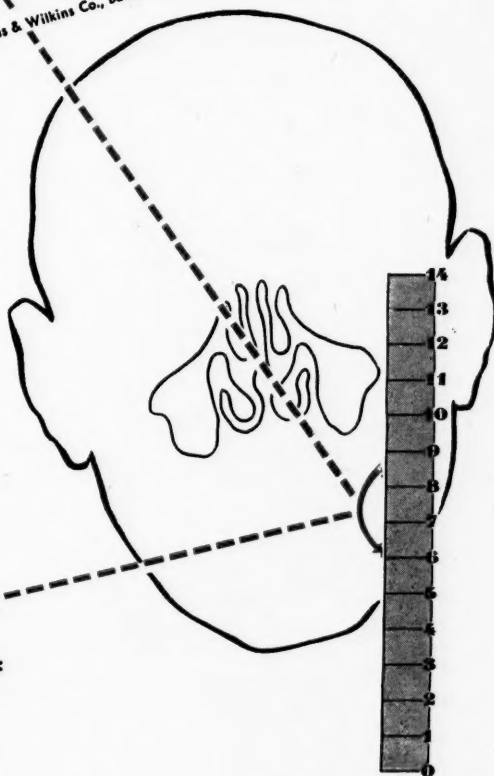
c. Hospital Staff. (1) Medical service, (2) Nursing service, (3) Social service, (4) Occupational and education service, (5) Pathological service, (6) Business service, (7) Maintenance service, (8) Steward of operations, (9) Religious service, (10) Such other services as may be organized

continued on page 146

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WELFARE COMMISSION RECOMMENDATIONS

continued from page 144

by the superintendent subject to the approval of the board of trustees.

d. *Administrative Council.* Of every one of these departments there shall be a chief selected by the superintendent with due regard to education and standards attained by the individuals. The chiefs of the services above enumerated shall be members of the hospital administrative council. The superintendent and the clinical director shall also be members and, in addition to the above, one member of the board of trustees and one from the visiting staff. The superintendent or his appointed representative shall be chairman.

The primary function of this administrative council is to consider what is best for the individual patient. The patient's disease, his progress in the institution, and his social life on release shall be subjects for discussion by the group. Meetings shall be held at stated intervals, attendance records shall be kept and records of the discussion shall be made on a form provided for that purpose. All actions of the council concerning individual patients shall be of a confidential nature and the records of such actions shall not be available to the public. Access to such records shall be obtained only in accordance with rules and regulations made by the superintendent and approved by the board of trustees. The main reason for which this Commission recommends the establishment of such an administrative council is to bring to the surface department organization, which can be observed and studied and the dignity of whose actions can be appreciated, to make the administration of our hospitals an open book, and to prevent the secret wielding of power by unauthorized employees within the institutions which constitutes the "grapevine".

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